

Youth Conservation Corps Medical History

NOTE: The collection of this information is authorized by Public Law 93-408. The purpose of this data is to safeguard the health, safety and welfare of the enrollees of the YCC programs and may be provided to a physician in the event treatment is necessary. This information is requested on a voluntary basis; however, failure to complete this form will result in exclusion from the program.

Part I - To be completed by applicant

1. Name (Last, First, Middle Initial)	2. Address (Street, City, State, including Zip Code)
---------------------------------------	--

3. Do you have health and accident insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, list name of insurer in block 4.	4. Insured by and policy number	5. Date of birth (mm/dd/yyyy)
--	---------------------------------	-------------------------------

6. Have you had or are you having any of the following health conditions (Enter x where appropriate and describe on back)				
Allergies <input type="checkbox"/> Hay fever <input type="checkbox"/> Asthma <input type="checkbox"/> Poison ivy or oak <input type="checkbox"/> Insects stings <input type="checkbox"/> Skin condition <input type="checkbox"/> Other (Identify) _____	Frequent infections <input type="checkbox"/> Cold <input type="checkbox"/> Sore throat <input type="checkbox"/> Ear ache <input type="checkbox"/> Bladder or intestinal infection <input type="checkbox"/> Other (Identify) _____	Other health conditions <input type="checkbox"/> Chest pains <input type="checkbox"/> Convulsions <input type="checkbox"/> Diabetic <input type="checkbox"/> Difficulty with balance <input type="checkbox"/> Fainting <input type="checkbox"/> Heart condition <input type="checkbox"/> Hernia	<input type="checkbox"/> Rheumatism or arthritis <input type="checkbox"/> Loss of weight <input type="checkbox"/> Lyme disease <input type="checkbox"/> Mental Health Condition <input type="checkbox"/> Persistent cough <input type="checkbox"/> Problem with blood not clotting	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Sleepwalking <input type="checkbox"/> Swollen or painful joints <input type="checkbox"/> Ulcers <input type="checkbox"/> Other(Identify) _____

7. a. Are you currently taking any medication? <input type="checkbox"/> Yes- if yes, explain on back <input type="checkbox"/> No	b. Are you allergic to any medications? <input type="checkbox"/> Yes- if yes, explain on back <input type="checkbox"/> No
--	---

8. Immunization history (Enter X where appropriate and dates as indicated. A Tetanus and Diphtheria shot is required unless you have received one or a booster within the last ten years.)		
	Date of original series	Date of Last Booster to ensure Immunization
<input type="checkbox"/> Diphtheria		
<input type="checkbox"/> Polio Vaccine		
<input type="checkbox"/> Tetanus Toxoid		

To my knowledge, I have not been exposed to a contagious or infectious disease in the past three weeks, and I am in a state of health which would allow full participation in all YCC activities.

Signature (Read the statement above before signing)	Date (mm/dd/yyyy)
---	--------------------------

Part II - To be completed by parent or guardian of the applicant		
This is to certify that I am familiar with the Youth Conservation Corps Program and that I give my consent to my son/daughter/ward to participate with the program as a YCC member. I understand that I will not hold the United State Government responsible for any nonprogram accident or illness, and I authorize first aid, or emergency medical care, to be perform at the nearest, most adequate facility approved by the YCC.		
1. Emergency contact (Name and Relationship)	2. Home Phone () -	3. Work Phone () -
4. Address (Street, City, State and Zip Code)		
5. Signature (Parent or Guardian)		6. Date (mm/dd/yyyy)
Identify in remarks block, any condition that would restrict full participation and describe any special care or treatment that may be required.		
Basic functional requirements for outdoor work		
a. Heavy lifting, 45 pounds and over b. Heavy carrying, 45 pounds and over c. Straight pulling d. Pulling hand over hand e. Pushing f. Reaching above shoulder	g. Use of fingers h. Both hands required i. Walking j. Standing k. Crawling l. Kneeling	m. Repeated bending n. Climbing, legs only o. Climbing, use of legs and arms p. Both legs required q. Far vision correctable in one eye to 20/20 and to 20/40 in the other r. Hearing (aid permitted)
Environmental factors		
a. Outside b. Excessive heat c. Excessive Cold d. Excessive humidity e. Excessive dampness or chilling	f. Dry atmospheric conditions g. Excessive noise, intermittenet h. Dust i. Slippery or uneven walking surfaces j. Working around moving objects or vehicles	k. Working on ladders or scaffolding l. Working with hands in water m. Working closely with others n. Working alone
REMARKS <i>(Enter information regarding any prescribed medication, reactions to penicillin or any drugs and/or any other health problems of which we should be made aware.)</i>		
PRIVACY ACT STATEMENT FOR THE YCC MEDICAL HISTORY (FS-1800-3) 10/94		
The following information is provided to comply with the Privacy Act of 1974 (PL-579). 5 U.S.c. 301 and 7 CFR 260 authorize acceptance of the information requested on this form. Collecting this information is necessary to assist the agency in safeguarding the health, safety, and welfare of the enrollees of the YCC programs and may be provided to a physician in the event treatment is necessary. This information is requested on a voluntary basis, failure to complete this form will result in exclusion from the program. Privacy Act System of Records USDA/FS-27 Enrollee Medical Records covers the collection and storage of, and access to these records.		
BURDEN STATEMENT		
According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0596-0084. The time required to complete this information collection is estimated to average 20 minutes/hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. The U.S. Department of Agriculture (USDA) prohibits discrimination in all its programs and activities on the basis of race, color, national origin, gender, religion, age, disability, political beliefs, sexual orientation, and marital or family status. (Not all prohibited bases apply to all programs.) Persons with disabilities who require alternative means for communication of program information (Braille, large print, audiotape, etc.) should contact USDA's TARGET Center at 202-720-2600 (voice and TDD). To file a complaint of discrimination, write USDA, Director, Office of Civil Rights, 1400 Independence Avenue, SW, Washington, DC 20250-9410 or call (800) 795-3272 (voice) or (202) 720-6382 (TDD). USDA is an equal opportunity provider and employer.		
7. FS Reviewing officer's signature		8. Date (mm/dd/yyyy)